Touchstone
MEDICAL IMAGING

CT Contrast Form

PATIENT NAME:_____ **PATIENT ID#:**_____ **DOB:**_____
LAST FIRST MIDDLE

EXAM:_____ **DATE OF SERVICE:**_____

Do you have any history of the following? For your safety, please answer completely.

What is your weight?_____

☐ Yes ☐ No Are you allergic to Iodine?
☐ Yes ☐ No Have you had any IV contrast within the past 48 hours?
☐ Yes ☐ No Do you have both kidneys?
☐ Yes ☐ No History of Kidney surgery or Renal failure
☐ Yes ☐ No Asthma or lung problems
☐ Yes ☐ No Collagen Vascular Disease (lupus, rheumatoid arthritis, scleroderman, polymyositis)
☐ Yes ☐ No Heart problems
☐ Yes ☐ No History of cancer; If yes, explain:_____
☐ Yes ☐ No Multiple Myeloma; If yes, explain:_____
☐ Yes ☐ No Metal Implants/Foreign Objects; If yes, explain:_____
☐ Yes ☐ No Are you allergic to any Medication or food? If yes, please list_____
☐ Yes ☐ No If yes to above, have you ever had a severe reaction? If yes, please list_____
☐ Yes ☐ No Do you currently take medications? If so, please list_____
☐ Yes ☐ No Diabetic
☐ Yes ☐ No If diabetic, do you take Metformin Medications (glucophage, glucovance, avadament, metaglip, fortamet, or riomet).
☐ Yes ☐ No Pregnant?

What are your symptoms?_____
How long have you had these symptoms?_____
☐ Yes ☐ No Have you had previous surgery to this area? If yes, please explain:_____
_____

☐ I have answered all the questions to the best of my knowledge and understand the information presented is correct.

_____ _____ _____
Patient/Parent/Legal Guardian Signature **Technologist Initials** **Date**

INTERNAL USE ONLY: Creatinine level_____ (Normal level: 0.5 - 1.5)

GFR:_____IV:_____Guage:_____CC:_____# Of Punctures:_____

Site:_____Coverage By:_____

Technologist:_____Lot:_____Exp:_____

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